

INSTRUCTOR • TEACHER • PRECEPTOR

Head-to-Toe Assessment Checkoff

Adult inpatient nursing | 90 observable criteria | Grading, feedback, and reassessment

Learner / setting	Evaluator / assessment
Learner: _____	Evaluator / credentials: _____
School / unit: _____	Date: _____ Attempt: _____ Start/end: _____
Scenario or de-identified patient code: _____	Setting: ☐ Clinical ☐ Simulation ☐ Skills lab

Scope: Routine comprehensive adult inpatient assessment. Complete vital signs before the detailed examination, but make an immediate safety survey on first contact. Adapt to baseline, disability, language, comfort, orders, and clinical stability. This is not a pediatric, obstetric, trauma, or advanced specialty examination. [1]

Set expectations before scoring

Select required skills, allowed references, time expectation, and approved omissions in advance. Require hands-on performance when safe and feasible. Accept verbalization only for predefined simulation limitations, clinical reasoning, or the emergency prompt. Score the learner's assessment, not whether the patient has expected findings.

Approved adaptations / verbal-only items: _____
 Required add-ons (if any): _____ Allowed resources: _____

Mark	Operational definition
2	Independent, complete, accurate, and safe; no task-specific prompt. Appropriate self-correction before proceeding is allowed.
1	Safe but incomplete or imprecise, or needs one non-directive prompt; no instructor rescue.
0	Omitted, incorrect, unsafe, or needs repeated/directive coaching or instructor intervention.
NA	Not applicable or contraindicated, with evaluator-approved reason. Do not use for an omitted required skill.
NO	Not observed or no opportunity. Requires later observation or an approved simulation; not a pass.

Safety rule [S] Every applicable [S] item must score 2. A score of 0 or 1 on a safety item prevents a pass on this attempt regardless of the total. Stop an unsafe action immediately and document the event. This is a proposed educational rule, not a national grading standard.

Pass calculation: Earned points ÷ (2 × applicable scored items) × 100. NA is excluded. Any unresolved NO makes the result incomplete. **Suggested threshold: 90%**, plus all safety items met. Local approved threshold: ____%. No threshold should be chosen after observing the learner.

Required emergency prompt for L2

Use when no actual deterioration occurs: "Your full-code patient suddenly becomes unresponsive and has only gasping breaths. What do you do now?" Expected: stop the routine assessment, activate emergency/code response, assess breathing and pulse together for no more than 10 seconds, and begin CPR/AED actions if no definite pulse, following current BLS. [13]

If a row contains several components, score 2 only when all applicable components are demonstrated. Record patient refusal or a contraindication and the safe follow-up plan; do not penalize an appropriate adaptation.

PERFORMANCE CHECKLIST 1 OF 6

Preparation, baseline, and vital signs

Learner: _____ Date: _____ Mark one box per row. [S] = safety-critical.

A. Preparation and immediate safety

ID	Observable criterion	2	1	0	NA	NO
A1	Reviews diagnosis, handoff, relevant orders, precautions, activity limits, and code status before routine assessment.	☐	☐	☐	☐	☐
A2	[S] Performs hand hygiene; uses required PPE and cleans reusable equipment before and after use.	☐	☐	☐	☐	☐
A3	[S] Verifies two approved patient identifiers against the correct record; does not use room number.	☐	☐	☐	☐	☐
A4	Checks allergies and reaction details; reconciles patient report with available documentation.	☐	☐	☐	☐	☐
A5	[S] Introduces name and role, explains assessment, obtains permission, and respects privacy or refusal.	☐	☐	☐	☐	☐
A6	Provides needed interpreter or communication aids; asks permission for visitors to remain.	☐	☐	☐	☐	☐
A7	Prepares supplies, locks bed, positions safely, and protects patient, lines, and tubes during movement.	☐	☐	☐	☐	☐
A8	[S] Immediately checks responsiveness, airway, breathing, and circulation; prioritizes urgent help over the routine checklist.	☐	☐	☐	☐	☐

Evidence / prompts / NA reason: _____

Section earned: _____ Applicable items: _____ Maximum: 2 × applicable = _____ Sources [1,9,10,13]

B. General survey, vital signs, and pain

ID	Observable criterion	2	1	0	NA	NO
B1	Asks the main concern and identifies what has changed from the patient's usual or recent baseline.	☐	☐	☐	☐	☐
B2	Observes appearance, distress, interaction, mood, and ability to participate; addresses immediate comfort needs.	☐	☐	☐	☐	☐
B3	Obtains or verifies current temperature, pulse, respirations, blood pressure, and SpO2 with appropriate technique and timing.	☐	☐	☐	☐	☐
B4	Records room air or oxygen device and flow/settings; checks the ordered oxygen target when applicable.	☐	☐	☐	☐	☐
B5	Compares vital signs with baseline and trends; validates unexpected readings without delaying needed assistance.	☐	☐	☐	☐	☐
B6	Screens for pain; assesses location, quality, severity, onset, radiation, triggers, and relief when present.	☐	☐	☐	☐	☐
B7	Assesses pain's functional impact, uses an appropriate scale, and identifies a relief and reassessment plan.	☐	☐	☐	☐	☐
B8	Reviews relevant intake/output, weight, laboratory results, and glucose data as indicated by the clinical situation.	☐	☐	☐	☐	☐

Evidence / prompts / NA reason: _____

Section earned: _____ Applicable items: _____ Maximum: 2 × applicable = _____ Sources [1,12,16]

PERFORMANCE CHECKLIST 2 OF 6

Neurological and head assessment

Learner: _____ Date: _____ Mark one box per row. [S] = safety-critical.

C. Neurological assessment

ID	Observable criterion	2	1	0	NA	NO
C1	Assesses level of consciousness, arousability, attention, and ability to follow appropriate commands.	☐	☐	☐	☐	☐
C2	Assesses orientation to person, place, time, and situation using the patient's communication method.	☐	☐	☐	☐	☐
C3	Assesses speech clarity, expression/comprehension, facial symmetry, and any change from baseline.	☐	☐	☐	☐	☐
C4	Measures pupil size and equality; assesses direct and consensual response to light in each eye.	☐	☐	☐	☐	☐
C5	Compares bilateral hand grips and upper-extremity movement/strength, respecting pain and movement restrictions.	☐	☐	☐	☐	☐
C6	Compares leg movement and foot dorsiflexion/plantar flexion strength bilaterally, within safe limits.	☐	☐	☐	☐	☐
C7	Compares light-touch sensation bilaterally; asks about new numbness, tingling, dizziness, headache, or weakness.	☐	☐	☐	☐	☐
C8	Recognizes new confusion or asymmetry; identifies need for focused neurologic, delirium, sedation, or glucose assessment.	☐	☐	☐	☐	☐

Evidence / prompts / NA reason: _____

Section earned: _____ Applicable items: _____ Maximum: 2 × applicable = _____ Sources [1,2]

D. Head, eyes, ears, nose, mouth, and neck

ID	Observable criterion	2	1	0	NA	NO
D1	Inspects head and face for injury, swelling, lesions, asymmetry, or new discomfort.	☐	☐	☐	☐	☐
D2	Asks about visual change; checks external eyes, drainage, and availability/use of vision aids.	☐	☐	☐	☐	☐
D3	Assesses hearing and communication needs; checks external ears, drainage, and hearing aids if used.	☐	☐	☐	☐	☐
D4	Inspects nose and visible neck for drainage, bleeding, swelling, asymmetry, or device-related injury.	☐	☐	☐	☐	☐
D5	Inspects oral mucosa, tongue, teeth/dentures, moisture, lesions, and oral-care needs with consent.	☐	☐	☐	☐	☐
D6	[S] Screens for swallowing difficulty and secretion control; follows NPO/swallow precautions rather than an unapproved oral trial.	☐	☐	☐	☐	☐

Evidence / prompts / NA reason: _____

Section earned: _____ Applicable items: _____ Maximum: 2 × applicable = _____ Sources [1,2,15]

Do not assume A routine oral inspection is not a formal swallow clearance. Do not document accommodation, a full cranial nerve exam, or other components that were not performed. [2,15]

PERFORMANCE CHECKLIST 3 OF 6

Respiratory and cardiovascular assessment

Learner: _____ Date: _____ Mark one box per row. [S] = safety-critical.

E. Respiratory assessment

ID	Observable criterion	2	1	0	NA	NO
E1	Asks about dyspnea, cough, sputum, pleuritic discomfort, and usual oxygen or breathing support.	☐	☐	☐	☐	☐
E2	Counts respirations for a full minute; describes rhythm, depth, work of breathing, and speech tolerance.	☐	☐	☐	☐	☐
E3	Inspects chest movement for symmetry and notes accessory muscle use, retractions, or abnormal positioning.	☐	☐	☐	☐	☐
E4	Interprets SpO2 with symptoms, oxygen delivery, perfusion, probe quality, and potential measurement limitations.	☐	☐	☐	☐	☐
E5	Positions and exposes appropriately; auscultates directly on skin, avoiding clothing and bony prominences.	☐	☐	☐	☐	☐
E6	Compares anterior and lateral lung fields side to side, including the right middle-lobe and lingular regions.	☐	☐	☐	☐	☐
E7	Compares posterior lung fields from apices through bases; hears a full breath cycle at each paired site.	☐	☐	☐	☐	☐
E8	Describes breath sounds and location of abnormalities; reassesses unexpected sounds and recognizes respiratory deterioration.	☐	☐	☐	☐	☐

Evidence / prompts / NA reason: _____

Section earned: _____ Applicable items: _____ Maximum: 2 × applicable = _____ Sources [1,3,12]

F. Cardiovascular and peripheral vascular

ID	Observable criterion	2	1	0	NA	NO
F1	Asks about chest discomfort, palpitations, dizziness/syncope, orthopnea, and new swelling.	☐	☐	☐	☐	☐
F2	Auscultates aortic, pulmonic, Erb's point, tricuspid, and mitral areas; identifies S1/S2 and unexpected sounds.	☐	☐	☐	☐	☐
F3	Counts the apical pulse for a full minute and describes rhythm; correlates with peripheral pulse/monitor as indicated.	☐	☐	☐	☐	☐
F4	Palpates and compares radial pulses bilaterally for presence, strength, and symmetry.	☐	☐	☐	☐	☐
F5	Assesses dorsalis pedis and posterior tibial pulses bilaterally; seeks Doppler or help when not palpable.	☐	☐	☐	☐	☐
F6	Compares extremity color, warmth, and capillary refill; reports actual refill time and relevant asymmetry.	☐	☐	☐	☐	☐
F7	Assesses dependent/peripheral edema for location, laterality, and severity using the facility's descriptors or scale.	☐	☐	☐	☐	☐
F8	Recognizes unilateral limb swelling, warmth, or pain; avoids provocative clot testing or massage when thrombosis is suspected.	☐	☐	☐	☐	☐

Evidence / prompts / NA reason: _____

Section earned: _____ Applicable items: _____ Maximum: 2 × applicable = _____ Sources [1,4]

Technique safeguard Do not palpate both carotid arteries at once. Do not let monitor data replace direct patient assessment. Full carotid/bruit and jugular venous pressure examinations are assigned add-ons, not required core items. [4]

PERFORMANCE CHECKLIST 4 OF 6

Abdominal, elimination, and fluid assessment

Learner: _____ Date: _____ Mark one box per row. [S] = safety-critical.

G. Abdominal and gastrointestinal assessment

ID	Observable criterion	2	1	0	NA	NO
G1	Asks about abdominal pain, nausea/vomiting, appetite, food tolerance, and gastrointestinal history relevant to care.	☐	☐	☐	☐	☐
G2	Determines last bowel movement, usual pattern, flatus, stool changes, and any blood or black/tarry stool.	☐	☐	☐	☐	☐
G3	Confirms ordered diet/NPO status, swallowing precautions, and assistance needed for eating.	☐	☐	☐	☐	☐
G4	Positions with the abdomen relaxed; inspects contour, symmetry, distention, scars, and visible abnormalities.	☐	☐	☐	☐	☐
G5	Auscultates all four quadrants before palpation; follows local listening-duration criteria before reporting absent sounds.	☐	☐	☐	☐	☐
G6	Uses light palpation as appropriate; examines a painful area last and notes tenderness, guarding, or rigidity.	☐	☐	☐	☐	☐
G7	Stops an unsafe or poorly tolerated examination and recognizes significant pain, bleeding, or acute abdominal change.	☐	☐	☐	☐	☐
G8	Assesses nutrition/hydration concerns and identifies need for focused follow-up rather than relying on bowel sounds alone.	☐	☐	☐	☐	☐

Evidence / prompts / NA reason: _____

Section earned: _____ Applicable items: _____ Maximum: 2 × applicable = _____ Sources [1,5,15]

H. Genitourinary and fluid balance

ID	Observable criterion	2	1	0	NA	NO
H1	Asks about usual voiding, last void, dysuria, urgency, retention, incontinence, and renal/dialysis baseline if relevant.	☐	☐	☐	☐	☐
H2	Assesses urine amount, time interval, color, clarity, and blood when observable; distinguishes measured from reported output.	☐	☐	☐	☐	☐
H3	Assesses suprapubic discomfort/distention when indicated and identifies need for a bladder scan or focused evaluation.	☐	☐	☐	☐	☐
H4	If catheterized, checks securement, unobstructed tubing, closed system, and bag below bladder and off the floor.	☐	☐	☐	☐	☐
H5	If catheterized, assesses the indication and ongoing need; identifies related hygiene and skin-care needs.	☐	☐	☐	☐	☐
H6	Reconciles intake/output and weight trends; recognizes reduced output, fluid deficit, or overload relative to baseline.	☐	☐	☐	☐	☐

Evidence / prompts / NA reason: _____

Section earned: _____ Applicable items: _____ Maximum: 2 × applicable = _____ Sources [1,5,11]

Technique safeguard Abdominal auscultation precedes palpation. Percussion, deep palpation, and provocative maneuvers require an explicit learning objective and safe clinical indication; they are not automatic core requirements. [5]

PERFORMANCE CHECKLIST 5 OF 6

Mobility, posterior surfaces, and skin

Learner: _____ Date: _____ Mark one box per row. [S] = safety-critical.

I. Musculoskeletal, mobility, and function

ID	Observable criterion	2	1	0	NA	NO
I1	Asks about pain, falls, dizziness, joint limitations, usual mobility, and assistive devices.	☐	☐	☐	☐	☐
I2	Inspects alignment, movement, swelling, and deformity; compares extremities with baseline.	☐	☐	☐	☐	☐
I3	Assesses active range of motion and functional strength without forcing painful or restricted movement.	☐	☐	☐	☐	☐
I4	Assesses bed mobility, sitting balance, transfers, and gait only when safe and consistent with activity orders.	☐	☐	☐	☐	☐
I5	[S] Uses the required assistance and equipment; respects weight-bearing and fall precautions during mobility assessment.	☐	☐	☐	☐	☐
I6	Assesses ability to perform daily activities; identifies fall risk, assistance level, and rehabilitation needs.	☐	☐	☐	☐	☐

Evidence / prompts / NA reason: _____

Section earned: _____ Applicable items: _____ Maximum: 2 × applicable = _____ Sources [1,2,6]

J. Skin, posterior surfaces, and wounds

ID	Observable criterion	2	1	0	NA	NO
J1	Inspects skin throughout the examination for color change, moisture, bruising, rash, lesions, and integrity.	☐	☐	☐	☐	☐
J2	Assesses temperature, tenderness, edema, and hydration cues; interprets findings in relation to baseline skin tone.	☐	☐	☐	☐	☐
J3	Repositions with appropriate help to inspect the back, sacrum/coccyx, buttocks, and other dependent areas with consent.	☐	☐	☐	☐	☐
J4	Inspects pressure areas, including occiput, ears, elbows, hips, ankles, and heels, as accessible and indicated.	☐	☐	☐	☐	☐
J5	Checks skin beneath/around devices, folds, and moisture-prone areas without disrupting required treatment.	☐	☐	☐	☐	☐
J6	Assesses wounds/incisions and dressings for location, drainage, odor, pain, surrounding changes, and dressing integrity.	☐	☐	☐	☐	☐
J7	Measures exposed wounds when indicated; uses approved terminology and does not guess a pressure injury stage.	☐	☐	☐	☐	☐
J8	Completes the required skin-risk assessment and initiates individualized repositioning, offloading, and moisture care.	☐	☐	☐	☐	☐

Evidence / prompts / NA reason: _____

Section earned: _____ Applicable items: _____ Maximum: 2 × applicable = _____ Sources [1,7]

Respect clinical limits Do not force ambulation, range of motion, turning, or dressing removal to complete a checklist. Document the limitation and a safe plan to obtain the missing assessment. [1,6,7]

PERFORMANCE CHECKLIST 6 OF 6

Devices, clinical judgment, and completion

Learner: _____ Date: _____ Mark one box per row. [S] = safety-critical.

K. Lines, tubes, drains, and treatment devices

ID	Observable criterion	2	1	0	NA	NO
K1	[S] Identifies present devices, traces connections from patient to source, and protects them from dislodgement or misconnection.	☐	☐	☐	☐	☐
K2	If vascular access is present, assesses site, dressing, securement, tenderness, leakage, and infiltration/infection cues.	☐	☐	☐	☐	☐
K3	If infusions are running, compares solution/medication, ordered rate, pump settings, labels, and alarms within scope.	☐	☐	☐	☐	☐
K4	If an enteral tube is present, checks external marking, securement, site, approved placement verification, and tolerance.	☐	☐	☐	☐	☐
K5	If a chest tube is present, assesses site, connections, ordered system, drainage, and system-specific indicators without routine clamping.	☐	☐	☐	☐	☐
K6	If an ostomy or surgical drain is present, assesses site/stoma, surrounding skin, ordered function, and time-defined output.	☐	☐	☐	☐	☐
K7	If an artificial airway/support device is present, assesses security, site/skin, secretions, support settings, and emergency readiness within competency.	☐	☐	☐	☐	☐
K8	Checks other present devices, such as wound therapy, dialysis access, or compression equipment, using the relevant competency and orders.	☐	☐	☐	☐	☐

Evidence / prompts / NA reason: _____

Section earned: _____ Applicable items: _____ Maximum: 2 × applicable = _____ Sources [1,8,11,17]

L. Clinical judgment, communication, and completion

ID	Observable criterion	2	1	0	NA	NO
L1	Summarizes relevant findings, distinguishes baseline from new changes, and prioritizes the most important concern.	☐	☐	☐	☐	☐
L2	[S] Responds to actual deterioration or the required emergency prompt with immediate help and appropriate first actions.	☐	☐	☐	☐	☐
L3	Communicates significant findings using SBAR; states urgency, recommendation, and follow-up responsibility.	☐	☐	☐	☐	☐
L4	Initiates appropriate measures within role/orders and reassesses the patient's response at an appropriate interval.	☐	☐	☐	☐	☐
L5	[S] Documents only findings actually assessed or clearly attributed; records limitations, notifications, actions, and reassessment.	☐	☐	☐	☐	☐
L6	Explains findings and next steps in understandable terms; addresses questions and checks understanding.	☐	☐	☐	☐	☐
L7	Restores comfort and needed positioning; provides assistance with toileting and personal items as appropriate.	☐	☐	☐	☐	☐
L8	[S] Leaves bed low and locked, call light accessible, needed alarms/precautions active, and patient safely attended or handed off.	☐	☐	☐	☐	☐

Evidence / prompts / NA reason: _____

Section earned: _____ Applicable items: _____ Maximum: 2 × applicable = _____ Sources [1,9,13,14]

Conditional devices Mark absent devices NA with a reason. Device assessment does not authorize untrained manipulation, connection changes, medication administration, or adjustment of prescribed settings. [8,11,17]

EVALUATION RECORD

Score, feedback, and reassessment

Learner: _____ Evaluator: _____

Section	Rows	NA	NO	Applies ¹	Earned	Max ²
A Preparation and immediate safety	8					
B General survey, vital signs, and pain	8					
C Neurological assessment	8					
D Head, eyes, ears, nose, mouth, and neck	6					
E Respiratory assessment	8					
F Cardiovascular and peripheral vascular	8					
G Abdominal and gastrointestinal assessment	8					
H Genitourinary and fluid balance	6					
I Musculoskeletal, mobility, and function	6					
J Skin, posterior surfaces, and wounds	8					
K Lines, tubes, drains, and treatment devices	8					
L Clinical judgment, communication, and completion	8					

¹ Applies = rows minus NA; resolve every NO before calculating a final score. ² Max = applies × 2.
 Earned = (number of 2s × 2) + number of 1s. All 90 applicable items would yield 180 possible points.

Total earned: _____ **Total maximum:** _____ **Percentage:** _____% **Required:** _____%

Safety review: A2, A3, A5, A8, D6, I5, K1, L2, L5, L8.

All applicable safety items scored 2: ☐ Yes ☐ No Unresolved NO: ☐ Yes ☐ No

Outcome: ☐ Pass ☐ Not yet competent ☐ Incomplete / further observation required

Feedback / evidence	Action and reassessment plan
Strengths / effective clinical reasoning: _____ _____	Priority criterion IDs: _____ Practice or learning activity: _____ _____
Safety event / omitted skill / prompt given: _____ _____	Reassessment date: _____ Required demonstration: _____ _____

Learner signature: _____ Evaluator signature: _____

Reassessment: Date _____ Criterion IDs _____ Result _____ Evaluator _____

Signatures acknowledge review. Any later competency decision must be supported by documented reassessment. Keep the original attempt; do not silently replace prior scores.

SOURCE NOTES

References and local adaptation

Bracketed numbers in the text refer to the entries below. Source organizations did not validate or endorse these documents.

- [1] Open RN / WisTech Open. Nursing Skills 2e (2023). [Appendix C: Head-to-Toe Assessment Checklist](#)
- [2] Open RN. Neurological and head assessment. [6.10 Neurological Assessment](#); [6.7 Motor Strength](#); [7.4 Head and Neck](#); [8.3 Eye and Ear](#)
- [3] Open RN. Respiratory assessment. [10.3 Respiratory Assessment](#)
- [4] Open RN. Cardiovascular assessment. [9.3 Cardiovascular Assessment](#)
- [5] Open RN. Abdominal assessment. [12.3 Gastrointestinal and Genitourinary Assessment](#)
- [6] Open RN. Mobility and function. [13.4 Musculoskeletal Assessment](#)
- [7] Open RN. Skin and wounds. [14.4 Integumentary Assessment](#); [20.3 Assessing Wounds](#)
- [8] Open RN. Tubes and vascular access. [17.2 Enteral Tube Basics](#); [17.3 Enteral Tube Assessment](#); [23.4 IV Site Assessment](#)
- [9] Centers for Disease Control and Prevention (2024). [Standard Precautions for All Patient Care](#)
- [10] Joint Commission. Updated April 21, 2026. [Two Patient Identifiers: Understanding the Requirements](#)
- [11] Centers for Disease Control and Prevention (2024). [CAUTI: Summary of Recommendations](#)
- [12] U.S. Food and Drug Administration. [Pulse Oximeters: Uses, Limitations, and Skin Pigmentation](#)
- [13] American Heart Association (2025). [Part 7: Adult Basic Life Support](#)
- [14] Agency for Healthcare Research and Quality. [TeamSTEPPS: SBAR Communication Tool](#)
- [15] American Speech-Language-Hearing Association. [Practice Portal: Adult Dysphagia](#)
- [16] Open RN. General survey. [1.3 Vital Signs](#)
- [17] British Thoracic Society (2023; current online version). [Clinical Statement on Pleural Procedures](#)

Adaptation and use

Clinical content is adapted and synthesized from the sources above. Open RN Nursing Skills 2e, edited by Kimberly Ernstmeier and Elizabeth Christman, is © 2023 WisTech Open and licensed under Creative Commons Attribution 4.0. Wording, organization, teaching prompts, and the grading framework have been modified for these companion tools.

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Local review: Approve the scope, assessment technique, pass threshold, escalation expectations, and required device competencies before formal use. This is an educational template, not a psychometrically validated instrument or an institutional policy.

Reviewed by: _____ Role: _____ Date: _____